



PATIENT REQUEST FOR HEALTH INFORMATION

PATIENT INFORMATION (PLEASE PRINT)

Form with fields for Patient Name, Address, City/State/Zip, Date of Birth, and Phone #.

WHAT RECORDS DO YOU WANT?

I understand that this information may include information relating to: AIDS, HIV, diagnosis/treatment of drug or alcohol abuse; mental, behavioral health, or psychiatric care.

Form with checkboxes for various record types: Summary, Discharge Summary, History/Physical, Emergency Room Record, Operative Report(s), Laboratory Reports, Radiology Reports, Radiology Images, and Other. Includes a Date(s) of Service field.

HOW WOULD YOU LIKE YOUR RECORDS DELIVERED?

Form with checkboxes for delivery methods: Paper, CD, Email, and Other. Includes a warning about PHI in transit and a signature line for the patient.

WHERE DO YOU WANT YOUR RECORDS SENT?

Form with checkboxes for recipient selection (Myself or My Personal Representative) and fields for Recipient Name, Telephone #, Street Address, City/State/Zip, and Fax or Email.

Hillcrest Health System recognizes a patient's right under HIPAA to access copies of his/her health information. There may be charges associated with processing a request and producing requested records.

Signature of Patient/Authorized Representative

Date

Printed Name of Patient or Legal Guardian

Relationship to patient, if other than self (attach appropriate legal documents)

Please Return Completed Form to: HIM Department, 1120 S. Utica Ave, Tulsa, OK 74104

For questions about completing this form please call 918-579-2000

For Hospital Staff use:

MR/Acct #: \_\_\_\_\_ ID Verified: \_\_\_\_\_

Processed by: \_\_\_\_\_ on \_\_\_\_\_ via \_\_\_\_\_

Notes: \_\_\_\_\_